

State Efforts to Insure the Uninsured

An Unfinished Story

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Key findings:

- **Regulatory reform did not increase the number of small businesses offering insurance.**
- **Health insurance purchasing alliances also had little effect.**
- **Subsidizing public insurance expands coverage, but large reductions in the uninsured would require large subsidies.**
- **Expanding public insurance causes some individuals to replace private insurance with public coverage, increasing the costs of public programs.**
- **Expanding the safety net might be more effective in improving the health of some disadvantaged populations than providing insurance would be.**

About 41 million Americans—one in seven adults—were uninsured in 2001. There is convincing evidence that being uninsured adversely affects access to health care, and an overwhelming majority of the American public views the problem of the uninsured as a significant policy issue.

Over the past decade, the states have been the laboratories for trying new approaches to insuring the uninsured. These include regulatory reform, adopting purchasing alliances, expanding public programs, providing new public subsidies, and shoring up the safety net—the configuration of public hospitals and clinics that provide health care to those without insurance.

Reforms in the market for small-group insurance and small-group purchasing alliances are intended to make insurance more accessible and affordable for small businesses, which are less likely to offer insurance to their workers than are larger firms. Expanding the availability of group insurance targets the 40 percent of the uninsured who work in small businesses and their dependents. Expanding public programs and new public subsidies are intended to make insurance more readily available and affordable to low-income uninsured persons, regardless of their work status.

A series of studies conducted by RAND economists Susan Marquis and Stephen Long have examined how successful these state experiments have been. Overall, the results show that states have not yet solved the problem of the uninsured. But the experiments have provided important lessons for policymakers that may help to shape the next wave of programs.

This Highlight summarizes RAND research reported in the following publications:

Long SH, Marquis MS. Have Small-Group Health Insurance Purchasing Alliances Increased Coverage? *Health Affairs*, Vol. 20, No. 1, 2001, pp. 154–163.

Long SH, Marquis MS. Participation in a Public Insurance Program: Subsidies, Crowd-Out, and Adverse Selection, *Inquiry*, Vol. 39, No. 3, Fall 2002, pp. 243–257.

Marquis MS, Long SH. Effects of “Second Generation” Small Group Health Insurance Market Reforms, 1993 to 1997, *Inquiry*, Vol. 38, Winter 2001/2002, pp. 365–380.

Marquis MS, Long SH. Federalism and Health System Reform: Prospects for State Action, *Journal of the American Medical Association*, Vol. 278, No. 6, 1997, pp. 514–517. Also available as RAND RP-647.

Marquis MS, Long SH. Public Insurance Expansions and Crowd Out of Private Coverage, *Medical Care*, Vol. 41, No. 3, March 2003, pp. 344–356.

Marquis MS, Long SH. The Role of Public Insurance and the Public Delivery System in Improving Birth Outcomes for Low-Income Pregnant Women, *Medical Care*, Vol. 40, No. 11, November 2002, pp. 1048–1059.

Making Insurance More Accessible to Small Businesses

The "Second Generation" of Small-Group Health Insurance Market Reforms. In the mid-1990s, several state legislatures enacted a second generation of small-group health insurance reforms to eliminate insurer underwriting practices that prevent groups or individuals in a group from purchasing insurance. For example, the reforms required insurers to make all of their policies available to any employer who wished to purchase a policy. The intent was to make insurance more accessible for high-risk groups, that is, groups with members at risk for having high expenditures on health care.

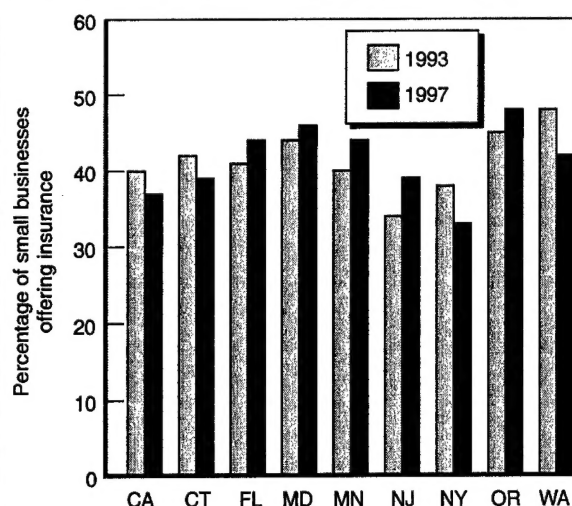
The reforms also governed how insurers could set premiums by restricting the extent to which premiums for a given set of benefits could vary across groups with different health characteristics. These reforms were intended to enlarge the risk pool on which premiums for small businesses are based, thereby making insurance more affordable for high-risk groups.

Marquis and Long compared the behavior of small business in nine states that adopted these reforms between 1993 and 1997 with the behavior of small business in 11 states and the District of Columbia, where neither type of reform existed before 1997. They drew their data from two large national surveys of employers—the 1997 Robert Wood Johnson Foundation (RWJF) Employer Health Insurance Survey and the National Employer Health Insurance Survey. The analysis focused on three basic outcomes: (1) the percentage of small businesses offering insurance and the percentage of employees enrolling, (2) small business decisions to add or drop insurance, and (3) the size and variability of premiums.

Overall, they found that the reforms had no effect on any of these outcomes. Figure 1 illustrates some of their findings. There were few significant differences in the percentage of employers offering insurance before and after the reforms and no consistent direction of effect across the states. Comparing the percentage of employees in firms offering insurance and the percentage of employees enrolled before and after the reforms reveals similar patterns.

The reforms also had no substantial effect on either the level or the variability of premiums in the small-group market. Some reform states had higher premiums than the nonreform states; others had lower premiums. However, although the reforms had little discernible effect on average, they may have improved access for the highest-risk employee groups.

Figure 1. Regulatory Reform Did Not Increase the Percentage of Small Businesses That Offered Insurance



Small-Group Health Insurance Purchasing Alliances.

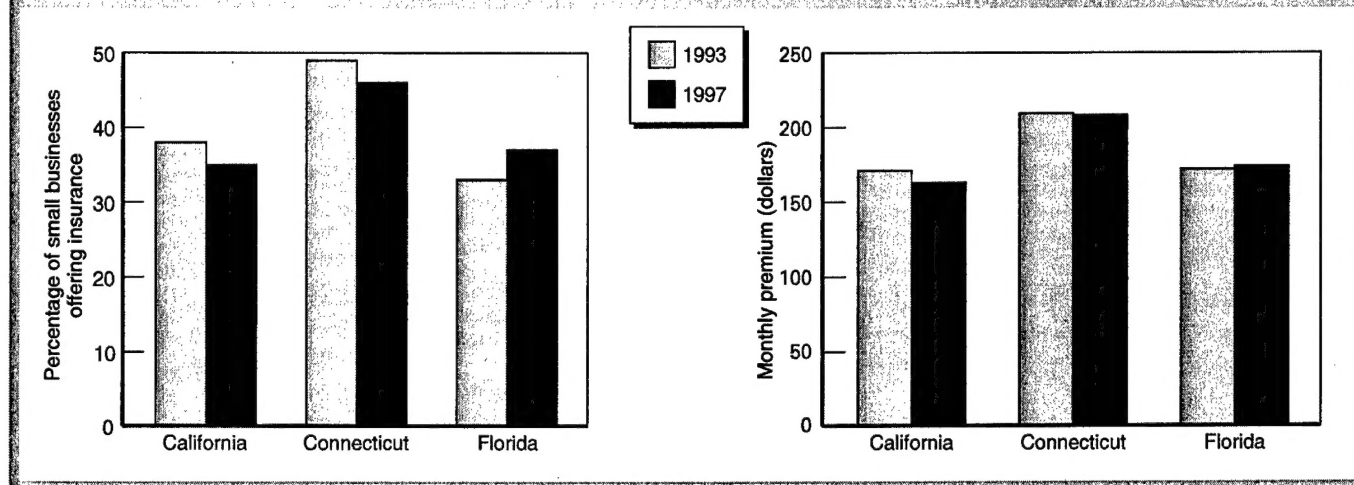
Health insurance purchasing alliances are intended to expand coverage by making insurance more affordable to groups of small businesses. In principle, alliances have lower administrative costs and give small groups collective purchasing power to negotiate lower rates from insurance carriers and plans. The alliance is also intended to stimulate competition in the rest of the small-group market, thus expanding coverage outside of the alliance as well.

Drawing on data from the 1997 RWJF Employer Health Insurance Survey, Marquis and Long examined the three states—California, Connecticut, and Florida—that had the largest statewide small-group alliances in the nation to see if the alliances increased coverage. The alliances encompassed a range of models, including both public and private sponsorship.

The researchers found that the alliances did not have their intended effects. They did not increase the percentage of small businesses that offered health insurance, nor did they reduce small-group market health insurance premiums. Figure 2 highlights some of their findings.

However, the alliances did permit participating employers to offer a much greater choice in the number and types of plans, and employees took advantage of these expanded options.

Figure 2. Small-Group Purchasing Alliances Did Not Have Their Intended Effects



Providing Subsidies and Expanding Public Programs

To increase coverage for the uninsured, many policymakers favor voluntary programs with financial assistance—such as tax credits, vouchers, or subsidized insurance—to help families obtain coverage. At the core of designing such programs are several critical questions, including the following:

- How large must the subsidy be to motivate the uninsured to enroll?
- Does expanding public programs lead some people to drop private insurance—“crowding out” private insurance?

How Large Must the Subsidy Be? Marquis and Long examined the experience of Washington State’s Basic Health (BH) program with these issues. The first state-subsidized insurance program in the country, it contracts with managed care plans to deliver services to participants. Individuals in families below 200 percent of the poverty level paid a sliding-scale premium ranging from \$10 to \$100 per month in 1997, as well as a small co-payment for most services.

The researchers modeled how changing the premium would affect enrollment. They found that lowering the premium for the BH program decreased the number of people who were uninsured. For example, reducing the premium from \$50 to \$25 per month decreased the proportion of uninsured

adults by about 2 percentage points and dropped the uninsured rate among children by about 3 percentage points. Reducing the premium by an additional amount further decreased the number of uninsured (see Table 1).

Nonetheless, even with a modest premium of \$10 per month, about one-third of adults and nearly 10 percent of children would remain uninsured. This result, as well as other research (including work conducted by Marquis and Long), suggests that substantially decreasing the ranks of the uninsured will require very large subsidies.

Do Public Programs Crowd Out Private Insurance? An important concern in evaluating the success of public programs is whether public coverage is substituting for—crowding out—private insurance. Crowd-out could happen in two ways: (1) Some people drop their private insurance to take advantage of the lower premium in the public program, or (2) some employers drop health insurance as an employee benefit because the public program offers an alternative. Crowd-out increases the cost of a public program because the state pays the insurance costs for some people who would otherwise have purchased private insurance.

To investigate crowd-out, Marquis and Long looked at what happened in seven states that expanded public coverage for a broad spectrum of their low-income population between 1991 and 1997. They used data from the Current Population Survey to study families’ decisions about insurance coverage,

Table 1. Lowering the Premium Reduced the Number of Uninsured

Percentage Uninsured	Monthly Premium for BH coverage		
	\$50	\$25	\$10
Adults	35%	32%	30%
Children	13%	10%	9%

and information from two large national employer surveys to examine how public programs influenced employers' decisions to offer insurance. They analyzed family and employer responses before and after the expansion of public insurance in the seven states and compared these changes with responses from those in a group of states without such expansions.

They found that expansions did increase the percentage of population enrolled in public programs in the seven target states. Participation in public programs grew by about 4 percentage points for adults and about 5 percentage points for children. In contrast, the percentage of low-income persons covered by private insurance fell in the seven states as a whole by about 3 percentage points more than expected based on insurance changes in the contrast states. These findings suggest that about 50 percent of those who newly participated in the public program substituted public insurance for private insurance.

Changes in employer-based coverage accord with this finding. In the seven expansion states, this coverage fell by about 3 percentage points more than would be expected from changes in the other states. Both the share of employees offered coverage and the share of employees who elected coverage if their firm offered it declined.

The expansion of public insurance had a bigger effect on small firms with a large share of low-wage workers, who would be eligible for the public programs. Firms with this kind of employee mix were more likely to stop offering coverage.

The experience of these seven states suggests that expanding access to public programs may indeed crowd out private insurance. Some public programs include design features, such as a waiting period, to try to explicitly prevent direct switching from private to public programs. But these design features raise issues of equity in the treatment of similar individuals.

Constraints on States' Ability to Expand Coverage

The studies summarized above demonstrate that state efforts have not eliminated the problem of the uninsured. Why have the states been unsuccessful?

One reason is that the tax capacity of some states makes them unable to cover their uninsured without federal help.

Marquis and Long examined the additional taxes that state residents would have to pay for a state program to subsidize coverage for low-income uninsured residents. There is substantial variation among states in the uninsured rate, which means that some states will have to spend more per capita than other states to attain equivalent outcomes in terms of covering their uninsured. In the early 1990s, the uninsured rate averaged 10 percent in the 12 states with the lowest uninsured rates, but was twice this in the 12 states with the highest uninsured rates.

The Marquis-Long analysis showed that, unfortunately, the states with the greatest need to extend coverage have the least capacity to do so. Nationwide, only half the states will be able to cover all of their uninsured with a budget limited to their tax capacity to finance health care reform. Thus many states will need financial assistance to introduce or expand programs to subsidize the purchase of insurance for their uninsured population.

Supporting the Safety Net

The analysis of Washington State's public insurance program suggests that even with fairly substantial subsidies some uninsured will remain. This highlights the need for a strong safety net to ensure access to care for these uninsured. In addition, evidence suggests that supporting the safety-net delivery system may result in better health outcomes in some cases. Efforts to improve maternal health outcomes provide an example.

Effectiveness of the Public Health System: Florida's Experience. Improving birth outcomes for low-income pregnant women has been an important health policy objective for two decades. Policymakers have pursued this goal in two ways: by expanding public insurance programs such as Medicaid, and by developing service delivery systems that typically include care coordination and combine nonmedical support services with clinical care. Marquis and Long examined Florida's experience with both of these approaches to help assess their effects.

Florida has nearly 200,000 births per year; both Medicaid and the county health departments play a significant role in financing maternal health care. Marquis and Long linked data from birth certificates, hospital records, Medicaid files, and county health department records to compare prenatal health care use and birth outcomes for four groups of low-income pregnant women, representing different financing approaches and different delivery systems:

- women on Medicaid who received prenatal care in the public health system
- women on Medicaid who received prenatal care from the private health care delivery system
- uninsured women who received prenatal care from the public health system
- uninsured women who received prenatal care from the private health care delivery system.

Providing public insurance increased the number of prenatal care visits per user. Women enrolled in Medicaid had significantly more visits than uninsured women, regardless of their choice of delivery system.

But birth outcomes were affected more by where low-income women receive care than by their insurance status. Women treated in the public health system had significantly better birth outcomes than women treated in the private system, whether they had Medicaid or were uninsured.

This analysis confirms that expanding public insurance does increase use of services. However, expansion by itself does not appear to lead to better outcomes. Instead, receiving care in the public health system, which provides care coordination and nonclinical support services, seems to be important for

improving outcomes for this population. These results suggest that expanding the safety net may be more effective in improving health for some disadvantaged populations than providing them with insurance and leaving them to navigate the health care system on their own.

Conclusions

States have tried a variety of approaches to expand health insurance coverage. Although none of these incremental approaches has eliminated the problem, policymakers have learned some valuable lessons.

A successful approach will likely involve multiple strategies. Regulations and purchasing alliances can help eliminate practices such as underwriting and administrative advantages that make insurance inaccessible to some groups. But large subsidies will be needed to enhance demand for coverage.

States are unlikely to be able to solve the problem of the uninsured on their own, especially in view of current constraints on state budgets. Large reductions in the uninsured will require new federal expenditures or innovative public/private approaches to financing. Many states are now pursuing this latter approach by using public money to pay the employee's share of employer group coverage for uninsured working families.

In a system in which purchasing health insurance is voluntary, we cannot expect to eliminate the uninsured. Maintaining a strong safety net will be necessary to ensure that those who remain uninsured have access to health care. State budget constraints put the safety net at risk. We need to ensure that the safety net's integrity does not erode.

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Employment-Based Health Insurance Selected RAND Research

Buchanan JL, Marquis MS. Who Gains and Who Loses with Community Rating for Small Business? *Inquiry*, Vol. 36, No. 1, 1999, pp. 30–43. Also available as RAND RP-793.

Long SH, Marquis MS. Have Small-Group Health Insurance Purchasing Alliances Increased Coverage? *Health Affairs*, Vol. 20, No. 1, 2001, pp. 154–163.

———. Participation in a Public Insurance Program: Subsidies, Crowd-Out, and Adverse Selection, *Inquiry*, Vol. 39, No. 3, Fall 2002, pp. 243–257.

———. Pooled Purchasing: Who Are the Players? *Health Affairs*, Vol. 18, No. 4, 1999, pp. 105–111. Also available as RAND RP-814.

Manning WG, Marquis MS. Health Insurance: The Tradeoff Between Risk Pooling and Moral Hazard, *Journal of Health Economics*, Vol. 15, 1996, pp. 609–639. Also available as RAND RP-616.

Marquis MS, Holmer MR. Alternative Models of Choice Under Uncertainty and the Demand for Health Insurance, *The Review of Economics and Statistics*, Vol. 78, No. 3, 1996, pp. 421–427. Also available as RAND RP-568.

Marquis MS, Long SH. Effects of “Second Generation” Small Group Health Insurance Market Reforms, 1993 to 1997, *Inquiry*, Vol. 38, Winter 2001/2002, pp. 365–380.

———. Federalism and Health System Reform: Prospects for State Action, *Journal of the American Medical Association*, Vol. 278, No. 6, 1997, pp. 514–517. Also available as RAND RP-647.

———. Prevalence of Selected Employer Health Insurance Purchasing Strategies in 1997, *Health Affairs*, Vol. 20, No. 4, July–August 2001, pp. 220–230.

———. To Offer or Not to Offer: The Role of Price in Employers’ Health Insurance Decisions, *Health Services Research*, Vol. 36, No. 5, October 2001, pp. 935–958.

———. The Role of Public Insurance and the Public Delivery System in Improving Birth Outcomes for Low-Income Pregnant Women, *Medical Care*, Vol. 40, No. 11, November 2002, pp. 1048–1059.

———. Worker Demand for Health Insurance in the Non-Group Market, *Journal of Health Economics*, Vol. 14, 1995, pp. 47–63. Also available as RAND RP-433.

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